

**SPECIAL PURPOSE MEDICAL LICENSE
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2007- 2009**

Date Received by Board

License No. _____

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

(For Board Use Only)

File No. _____

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

_____ RENEWAL FEE

\$850.00 ****(Save \$50.00 and renew online!)

Make checks payable to:

NEVADA STATE BOARD OF MEDICAL EXAMINERS

(Foreign checks must indicate "U.S. FUNDS")

PLEASE NOTE:

- A Special Purpose Medical License can be issued to a physician who is licensed in another state to permit the use of equipment that transfers information concerning the medical condition of a patient in the State of Nevada across state lines Electronically, telephonically or by fiber optics if the physician:
 - Holds a full and unrestricted license to practice medicine in that state;
 - Has not had any disciplinary or other action taken against him by any state or other jurisdiction; and
 - Meets the requirements set forth in paragraph (d) of subsection 2 of NRS 630.160 "Has completed 36 months of progressive postgraduate education".
- **WARNING:** A physician who holds a Special Purpose Medical License cannot physically practice medicine within the State of Nevada. The practice of medicine is defined by NRS 630.020(3), as follows:
 1. To diagnose, treat, correct, prevent or prescribe for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality.
 2. To apply principles or techniques of medical science in the diagnosis or the prevention of any such conditions.
 3. To perform any of the acts described in subsections 1 and 2 by using equipment that transfers information concerning the medical condition of the patient electronically, telephonically or by fiber optics.
- **YOUR CURRENT SPECIAL PURPOSE MEDICAL LICENSE EXPIRES ON JUNE 30, 2007. COMPLETED APPLICATION FOR REGISTRATION RENEWAL FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2007 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED APPLICATION FOR REGISTRATION RENEWAL FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS APPLICATION FOR REGISTRATION RENEWAL FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS APPLICATION FOR REGISTRATION RENEWAL FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone Number _____ Fax Number _____

2. Indicate below your primary and secondary scopes of practice using the following codes:

SCOPES OF PRACTICE CODES

1 ADDICTION MEDICINE	43 NEPHROLOGY	85 PEDIATRIC, SURGERY
2 ADOLESCENT MEDICINE	44 NEUROLOGY	86 PEDIATRIC, UROLOGY
3 AEROSPACE MEDICINE	45 NEURO-OPHTHALMOLOGY	87 PEDIATRICS
4 ALLERGY	46 NEUROPATHOLOGY	88 PHYSICAL MEDICINE/REHABILITATION
5 ALLERGY/IMMUNOLOGY	47 NEURORADIOLOGY	89 PREVENTIVE MEDICINE
6 AMBULATORY MEDICINE	48 NEUROTOLOGY	90 PSYCHIATRY
7 ANESTHESIOLOGY	49 NON-CONVENTIONAL MEDICINE	91 PSYCHOANALYSIS
8 BLOODBANKING	50 NUCLEAR MEDICINE	92 PSYCHOMATIC MEDICINE
9 BRONCO-ESOPHAGOLOGY	51 NUTRITION	93 PUBLIC HEALTH
10 CARDIOVASCULAR DISEASES	52 OBSTETRICS	94 PULMONARY DISEASES
11 CATSCAN/ULTRASOUND	53 OBSTETRICS/GYNECOLOGY	95 OCCUPATIONAL MEDICINE
12 CHILD NEUROLOGY	54 OCCUPATIONAL MEDICINE	96 RADIOLOGY
13 CHILD PSYCHIATRY	55 ONCOLOGY	97 RADIOLOGY, DIAGNOSTIC
14 CLINICAL PHARMACOLOGY	56 ONCOLOGY, GYNECOLOGICAL	98 RADIOLOGY, INTERVENTIONAL
15 CRITICAL CARE	57 ONCOLOGY, HEMATOLOGY	99 RADIOLOGY, NUCLEAR
16 DERMATOLOGY	58 ONCOLOGY, RADIATION	100 RADIOLOGY, THERAPEUTIC
17 DERMATOPATHOLOGY	59 ONCOLOGY, SURGICAL	101 RADIOLOGY, VASCULAR
18 EMERGENCY MEDICINE	60 OPHTHALMOLOGY	102 RHEUMATOLOGY
19 ENDOCRINOLOGY	61 OTOLARYNGOLOGY	103 RHINOLOGY
20 FAMILY PRACTICE	62 OTOTOLOGY	104 SLEEP DISORDERS
21 FORENSIC MEDICINE	63 PAIN MANAGEMENT	105 SPORTS MEDICINE
22 GASTROENTEROLOGY	64 PATHOLOGY	106 SURGERY, ABDOMINAL
23 GENERAL PRACTICE	65 PATHOLOGY, ANATOMIC	107 SURGERY, CARDIOTHORACIC
24 GERIATRIC PSYCHIATRY	66 PATHOLOGY, CLINICAL	108 SURGERY, CARDIOVASCULAR
25 GERIATRICS	67 PATHOLOGY, FORENSIC	109 SURGERY, COLON/RECTAL
26 GYNECOLOGY	68 PEDIATRIC, ALLERGY	110 SURGERY, CRANIOFACIAL
27 HAIR TRANSPLANTATION	69 PEDIATRIC, ANESTHESIOLOGY	111 SURGERY, GENERAL
28 HEMATOLOGY	70 PEDIATRIC, CARDIOLOGY	112 SURGERY, HAND
29 HOMEOPATHY	71 PEDIATRIC, CRITICAL CARE	113 SURGERY, HEAD/NECK
30 HYPNOSIS	72 PEDIATRIC, EMERGENCY MEDICINE	114 SURGERY, MAXILLOFACIAL
31 IMMUNOLOGY	73 PEDIATRIC, ENDOCRINOLOGY	115 SURGERY, NEUROLOGICAL
32 INFECTIOUS DISEASES	74 PEDIATRIC, GASTROENTEROLOGY	116 SURGERY, ORTHOPEDIC
33 INFERTILITY	75 PEDIATRIC, HEMATOLOGY/ONCOLOGY	117 SURGERY, PLASTIC
34 INTERNAL MEDICINE	76 PEDIATRIC, INFECTIOUS DISEASES	118 SURGERY, THORACIC
35 LARYNGOLOGY	77 PEDIATRIC, INTENSIVIST	119 SURGERY, TRANSPLANT
36 LEGAL MEDICINE	78 PEDIATRIC, NEPHROLOGY	120 SURGERY, TRAUMATIC
37 MATERNAL/FETAL MEDICINE	79 PEDIATRIC, NEUROLOGY	121 SURGERY, UROLOGIC
38 MEDICAL ACUPUNCTURE	80 PEDIATRIC, OPHTHALMOLOGY	122 SURGERY, VASCULAR
39 MEDICAL ETHICS	81 PEDIATRIC, PHYSIATRY	123 TOXICOLOGY
40 MEDICAL GENETICS	82 PEDIATRIC, PULMONARY	124 TRANSPLANTATION
41 NEO/PERINATAL MEDICINE	83 PEDIATRIC, RADIOLOGY	125 URGENT CARE
42 NEOPLASTIC DISEASES	84 PEDIATRIC, RHEUMATOLOGY	126 UROLOGY

Code

Code

Primary Scope of Practice _____

Secondary Scope of Practice _____

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**All of the following questions refer to the time period
July 1, 2005, through the present date only.**

For the purposes of the following questions, these phrases or words have these meanings:

“Ability to practice medicine” is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

“Medical condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

“Chemical substances” is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

**FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST
SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED
TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL FORM*.**

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _____ Yes _____ No
2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____ Yes _____ No _____ N/A
3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____ Yes _____ No _____ N/A
4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? _____ Yes _____ No _____ N/A
5. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? _____ Yes _____ No
6. Have you EVER been investigated for, arrested, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrests even if the ultimate disposition was dismissal or expungement. _____ Yes _____ No
7. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _____ Yes _____ No
8. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _____ Yes _____ No
9. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? _____ Yes _____ No
10. Have you EVER been denied membership or expelled from a medical society or other professional medical organization? _____ Yes _____ No
11. Have you EVER been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? _____ Yes _____ No
12. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____ Yes _____ No
13. Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation? _____ Yes _____ No
14. Are you a foreign medical doctor, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services? _____ Yes _____ No

15. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance). (If more space is needed, attach a separate sheet)

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
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CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

BY SIGNING ON THE SIGNATURE LINE BELOW:

- 1) I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REGISTRATION RENEWAL* OF SPECIAL PURPOSE MEDICAL LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;
- 2) I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND
- 3) I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (b) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).

BY SIGNING ON THE SIGNATURE LINE BELOW:

I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I UNDERSTAND HAVE ANSWERED THE QUESTIONS TRUE TO THE BEST OF MY KNOWLEDGE.

_____ Yes _____ No

_____ Date	_____ Signature (SIGNATURE STAMP UNACCEPTABLE)
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